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	HAL034116	A. BUILDING: _____ B. WING _____	R 05/03/2023

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SALEM TERRACE AND MEMORY CARE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 05/02/23 through 05/03/23.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure sanitation and safety guidelines were followed while providing feeding assistance to 2 of 2 residents (#2, #7) who required assistance with their meals. The findings are: Observation of the breakfast meal on 05/03/23 from 8:15am - 8:45am revealed: -Resident #2 and Resident #7 were seated at a table in the Special Care Unit (SCU) dining room.	D 283		

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-The Memory Care Coordinator (MCC) was seated in a chair between the two residents with Resident #7 on her left and Resident #2 on her right.
-The MCC was not wearing gloves while applying jelly to Resident #7's and Resident #2's biscuits.
-The MCC lifted Resident #7's biscuit to his mouth with an ungloved hand and without sanitizing or washing her hands.
-The MCC lifted a piece of bacon from Resident #7's plate to his mouth with an ungloved hand.
-The MCC wiped her hands on Resident #7's napkin and turned to her right to Resident #2 and lifted her biscuit to her mouth with an ungloved hand.
-The MCC did not wear gloves, sanitize or wash her hands as she continued to alternate bites of food and drink for each resident.
-The MCC did not wear gloves, sanitize or wash her hands as she alternated sips of drink between the two residents.
-The MCC used a napkin to occasionally wipe the residents' mouths without gloves, washing or sanitizing her hands between residents.

1. Review of Resident #2's current FL2 dated 03/31/23 revealed diagnoses included dementia, joint replacement and diabetes.

Review of Resident #2's assessment and care plan dated 04/11/23 revealed the activity of daily living documented Resident #2 as being totally dependent with eating.

Based on observations, record reviews and interviews, it was determined that Resident #2 was not interviewable.

Refer to the interview with a personal care aide (PCA) on 05/03/23 at 8:40am.

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D 283	Continued From page 2 Refer to the interview with a second PCA on 05/03/23 at 8:50am. Refer to the interview with the Memory Care Coordinator (MCC) on 05/03/23 at 8:58am. Refer to the interview with the Administrator on 05/03/23 at 2:15pm. 2. Review of Resident #7's current FL-2 dated 02/16/23 revealed: -Diagnoses included dementia and gastro esophageal reflux disease. -Resident #7 required personal care assistance with feeding. Review of Resident #7's assessment and care plan dated 02/21/23 revealed the activity of daily living documented Resident #7 as requiring limited assistance with eating, needing set up, cutting meats and opening cartons. Based on observations, record reviews and interviews, it was determined that Resident #7 was not interviewable. Refer to the interview with a personal care aide (PCA) on 05/03/23 at 8:40am. Refer to the interview with a second PCA on 05/03/23 at 8:50am. Refer to the interview with the Memory Care Coordinator (MCC) on 05/03/23 at 8:58am. Refer to the interview with the Administrator on 05/03/23 at 2:15pm. _____ Interview with the PCA on 05/03/23 at 8:40am	D 283		

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revealed:
-She was trained on assisting residents with eating when she first started working at the facility, but she could not remember when nor who trained her.
-She had been told to not wear gloves while providing feeding assistance to residents to provide dignity, even if touching the resident's food with bare hands.
-She was told to wash her hands between feeding residents.

Interview with a second PCA on 05/03/23 at 8:50am revealed:
-She was trained not to wear gloves, even when touching resident's food, when assisting residents with eating.
-She was trained when she started working at the facility, but could not remember when or who had trained her in feeding assistance.
-If she had to touch a resident's food, she would wash her hands before assisting a second resident.

Interview with the MCC on 05/03/23 at 8:58am revealed:
-Staff had not been trained to not wear gloves during feeding assistance for residents.
-She had worked at the facility for 10 years and could not remember who trained her.
-She could not say why she touched 2 different residents' food with bare hands without washing her hands or donning gloves.

Interview with the Administrator on 05/03/23 at 2:15pm revealed:
-She was not aware staff were feeding residents by touching their food without washing their hands or wearing gloves.
-Staff were trained not to wear gloves while

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D 283	Continued From page 4 providing feeding assistance but should have worn gloves or washed their hands when they needed to touch residents' food. -Staff should make every effort to use utensils while assisting with feeding residents. -The MCC was responsible for making sure staff were following sanitation guidelines while providing feeding assistance to residents.	D 283		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 8 ounces of milk was served twice daily to residents on the Special Care Unit (SCU). The findings are: Observation of the walk-in refrigerator in facility kitchen on 05/02/23 at 10:15am revealed there were 6 gallons of whole milk and 4 boxes of 48	D 299		

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D 299	Continued From page 5 count of 2% and whole milk in 8-ounce cartons. Review of the facility's week at a glance menu for week 1 for Tuesday revealed milk was not listed to be served with lunch on 05/02/23. Observation of the lunch meal service in the SCU on 05/02/23 between 11:45am and 12:35pm revealed: -The kitchen staff delivered 2 meal carts to the SCU dining room at 11:45am. -There were no containers of milk on either cart. -Thirty residents were served meals with tea but were not served or offered milk. -No medication aide (MA) or personal care aide (PCA) staff retrieved milk from the kitchen. Review of the facility's week at a glance menu for week 1 for Wednesday revealed a serving of milk was to be served with breakfast on 05/03/23. Observation of the breakfast meal service in the SCU on 05/03/23 between 8:15am and 8:45am revealed: -The kitchen staff delivered 2 meal carts to the SCU dining room at 8:15am. -There were 2 containers of orange juice and 2 containers of coffee, but no containers of milk on either cart. -Thirty residents were served meals with orange juice and coffee, but no milk was served or offered. -No MA or PCA asked for milk from the kitchen. Interview with a personal care aide (PCA) on 05/03/23 at 8:40am revealed: -Small cartons or gallons of milk were usually sent on the meal carts from the kitchen. -Milk was usually on the carts for the breakfast and dinner meal.	D 299		

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-If milk was not on the cart, a staff would have checked with the kitchen to get it.
-She did not realize that milk was not sent for breakfast 05/03/23.

Interview with a second PCA on 05/03/23 at 8:50am revealed:
-Milk was sent on the meal carts from the kitchen.
-The milk was usually on the carts for breakfast, but she was not sure if it was sent for dinner.
-When milk was not on the meal cart, a staff that was not providing feeding assistance would go to the kitchen to get the milk

Interview with a Memory Care Coordinator (MCC) on 05/03/23 at 8:58am revealed:
-Milk was sent on the meal carts from the kitchen.
-The milk was usually on the carts for each meal.
-She did not observe in the dining room during every meal and was not sure if milk had been sent for every meal on the meal carts.
-If milk did not come on the cart, a staff should have checked with the kitchen to provide them for the residents.
-She assisted with resident meals for breakfast on 05/03/23, but did not notice that residents were not served milk.
-She did not send staff to retrieve milk from the kitchen.

Interview with a dietary aide on 05/03/23 at 9:40am revealed:
-The dietary staff were responsible to send milk on the meal carts for SCU residents.
-She knew milk was to be served to residents for breakfast and dinner meals.
-A serving of milk was on the menu for 05/03/23 for the breakfast meal.
-The dietary staff had been rushed and did not place milk on the meal cart for SCU residents on

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D 299	Continued From page 7 05/03/23 for breakfast. -Care staff from the SCU did not come to the kitchen to ask for milk for breakfast 05/03/23. Interview with the Dietary Manager (DM) on 05/03/23 at 9:50am revealed: -The dietary staff were responsible to send milk on the meal carts for SCU residents. -He knew residents were to be served milk with breakfast. -The dietary staff had been rushed to get meal carts out to the SCU and did not place milk on the meal carton 05/03/23 for breakfast. -Staff from the SCU did not come to the kitchen to ask for milk for the breakfast meal service on 05/03/23. Interview with the Administrator on 05/03/23 at 2:15pm revealed: -She was not aware that milk had not been served for breakfast on 05/03/23 in the SCU. -If milk was not sent on meal carts, she expected staff to go immediately to the kitchen door and ask for milk for the residents. -She expected milk to be served to residents for meals according to the menu.	D 299		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages.	D 306		

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D 306	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure water was served at each meal, in addition to other beverages, in the Special Care Unit (SCU). The findings are: Observation of the lunch meal service in the SCU on 05/02/23 between 11:45am and 12:35pm revealed: -The kitchen staff delivered 2 meal carts to the SCU dining room at 11:45am. -There were no containers of water on either cart. -The residents were served meals with tea, but no water. -A personal care aide (PCA) retrieved a water pitcher from the kitchen at 12:14pm and stood in the middle of the dining room and asked who wanted water. -The staff served water to 3 or 30 SCU residents who answered or raised their hand at 12:14pm, 29 minutes into the meal. Observation of the breakfast meal service in the SCU on 05/03/23 between 8:15am and 8:45am revealed: -The kitchen staff delivered 2 meal carts to the SCU dining room at 8:15am. -There were 2 containers of orange juice and 2 containers of coffee, but no containers of water on either cart. -Residents were served meals with orange juice and coffee, but no water. -A PCA retrieved a water pitcher from the kitchen at 8:39am and asked who wanted water. -Staff served 4 of 30 SCU residents who answered or raised their hand at 8:39am, 24 minutes into the meal.	D 306		

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D 306	Continued From page 9 Interview with a PCA on 05/03/23 at 8:40am revealed: -Water pitchers were sent on the meal carts from the kitchen. -The water pitchers were usually on the carts for each meal. -If water was not on the cart, a staff would have checked with the kitchen to get the water pitchers. -She realized at the end of the meals for lunch 05/02/23 and breakfast 05/03/23 that residents did not have water and asked one of the other staff to get some water from the kitchen. Interview with a second PCA on 05/03/23 at 8:50am revealed: -Water was sent on the meal carts from the kitchen. -The water was usually on the carts for each meal. -When water was not on the meal cart, a staff that was not providing feeding assistance would go to the kitchen to get it. -She did not notice that residents did not have water with their breakfast. Interview with a Memory Care Coordinator (MCC) on 05/03/23 at 8:58am revealed: -Water was sent on the meal carts from the kitchen. -The water was usually on the carts for each meal. -She did not observe in the dining room every meal and so did not know if water had been sent for every meal on the meal carts. -If water did not come on the cart, a staff should have checked with the kitchen to provide water for the residents. -She assisted with resident meals for breakfast	D 306		

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05/03/23 but did not notice that residents were not served water.
-She did not send staff to retrieve water from the kitchen.

Interview with a dietary aide on 05/03/23 at 9:40am revealed:
-The dietary staff was responsible to send water on the meal carts for SCU residents.
-She knew water was to be served to residents at every meal.
-The dietary staff have just been rushed and did not place water on the meal cart for SCU residents on 05/02/23 for lunch and 05/03/23 for breakfast.
-A PCA from the SCU came to the kitchen later to ask for water for lunch 05/02/23 and breakfast 05/03/23.

Interview with the Dietary Manager (DM) on 05/03/23 at 9:50am revealed:
-The dietary staff were responsible to send water on the meal carts for SCU residents.
-He knew residents were to be served water with every meal.
-The dietary staff have just been rushed to get meal carts out to the SCU and did not place water on the meal cart on 05/02/23 for lunch and on 05/03/23 for breakfast.
-A PCA from the SCU came to the kitchen about a half an hour after carts were sent to ask for water for lunch 05/02/23 or breakfast 05/03/23.

Interview with the Administrator on 05/03/23 at 2:15pm revealed:
-She was not aware that water had not been served until later for lunch on 05/02/23 and breakfast on 05/03/23 in the SCU.
-If water was not sent on meal carts, she expected staff to go immediately to the kitchen

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D 306	Continued From page 11 door and ask for the water for the residents. -She expected water to be served to residents at the beginning of every meal.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a nutritional supplement was served as ordered for 3 of 3 sampled residents (#2, #6 and #4) observed during breakfast and lunch meal service (Resident #2 and #6) and a resident who had an order for a daily protein drink for wound healing (#4). The findings are: 1. Review of Resident #2's current FL2 dated 03/31/23 revealed diagnoses included dementia, joint replacement and diabetes. Review of Resident #2's physician's orders dated 3/31/23 revealed there was an order for a house supplement three times a day with meals. Observation of the lunch meal service in the Special Care Unit (SCU) on 05/02/23 between 11:45am and 12:35pm revealed: -The kitchen staff delivered 2 meal carts to the SCU dining room at 11:45am. -There were no nutritional supplements on either	D 310		

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cart.
-Resident #2 was served bar-b-que chicken, green beans, rice, roll, crème pie and unsweetened tea.
-A personal care aide (PCA) retrieved a water pitcher from the kitchen at 12:14pm, but did not return with any nutritional supplements.
-Resident #2 was provided feeding assistance by staff and consumed less than 25% of the meal.
-No nutritional supplement was served to Resident #2 during the lunch meal from 11:45am and 12:35pm.

Observation of the breakfast meal service in the SCU on 05/03/23 between 8:15am and 8:45am revealed:
-The kitchen staff delivered 2 meal carts to the SCU dining room at 8:15am.
-There were no nutritional supplements on either cart.
-Resident #2 was served scrambled eggs, grits, bacon, a biscuit and orange juice.
-A PCA retrieved a water pitcher from the kitchen at 8:39am, but did not return with any nutritional supplements.
-Resident #2 was provided feeding assistance by staff and consumed less than 50% of the meal.
-No nutritional supplement was served to Resident #2 during the breakfast meal from 8:15am and 8:45am.

Observation of the kitchen on 05/02/23 at 10:15am revealed Resident #2 was listed on the diet list to receive a house supplement 3 times a day with meals.

Observation of the kitchen freezer on 05/03/23 at 9:30am revealed there was a full box of nutritional supplements in a box in the freezer available to serve with meals.

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D 310	Continued From page 13 Based on observations, record reviews and interviews, it was determined that Resident #2 was not interviewable. Refer to the interview with a PCA on 05/03/23 at 8:40am. Refer to the interview with a second PCA on 05/03/23 at 8:50am. Refer to the interview with the Memory Care Coordinator (MCC) on 05/03/23 at 8:58am. Refer to the interview with a dietary aide on 05/03/23 at 9:40am. Refer to the interview with the Dietary Manager (DM) on 05/03/23 at 9:50am. Refer to the interview with the Administrator on 05/03/23 at 2:15pm. 2. Review of Resident #6's current FL2 dated 03/31/23 revealed: -Resident #6's diagnoses included dementia, schizophrenia and hyperlipidemia. -There was an order for a house supplement drink four times a day with meals and at bedtime. Observation of the lunch meal service in the Special Care Unit (SCU) on 05/02/23 between 11:45am and 12:35pm revealed: -The kitchen staff delivered two meal carts to the SCU dining room at 11:45am. -There were no nutritional supplements on either cart. -Resident #6 was served bar-b-que chicken, green beans, rice, roll, crème pie and tea. -Resident #6 ate 75 percent of her meal.	D 310		

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D 310	Continued From page 14 -A personal care aide (PCA) retrieved a water pitcher from the kitchen at 12:14pm, but did not return with any nutritional supplements. -No nutritional supplement was served to Resident #6 during the lunch meal from 11:45am and 12:35pm. Observation of the breakfast meal service in the SCU on 05/03/23 between 8:15am and 8:45am revealed: -The kitchen staff delivered two meal carts to the SCU dining room at 8:15am. -There were no nutritional supplements on either cart. -Resident #6 was served scrambled eggs, grits, bacon a biscuit and orange juice. -Resident #6 at nearly 100 percent of her meal. -A PCA retrieved a water pitcher from the kitchen at 8:39am, but did not return with any nutritional supplements. -No nutritional supplement was served to Resident #6 during the breakfast meal from 8:15am and 8:45am. Observation of the kitchen on 05/02/23 at 10:15am revealed Resident #6 was listed on the diet list to receive a house supplement 4 times a day with meals and at bedtime. Observation of the kitchen freezer on 05/03/23 at 9:30am revealed there was a full box of nutritional supplements in a box in the freezer available to serve with meals. Based on observations, record reviews and interviews, it was determined that Resident #6 was not interviewable. Refer to the interview with a PCA on 05/03/23 at 8:40am.	D 310		

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D 310	Continued From page 15 Refer to the interview with a second PCA on 05/03/23 at 8:50am. Refer to the interview with the Memory Care Coordinator (MCC) on 05/03/23 at 8:58am. Refer to the interview with a dietary aide on 05/03/23 at 9:40am. Refer to the interview with the Dietary Manager (DM) on 05/03/23 at 9:50am. Refer to the interview with the Administrator on 05/03/23 at 2:15pm. _____ Interview with a PCA on 05/03/23 at 8:40am revealed: -Nutritional supplements were sent on the meal carts from the kitchen. -Two residents were to receive nutritional supplements with their meals. -The nutritional supplements were usually on the carts for each meal. -If nutritional supplements were not on the cart, a staff would have checked with the kitchen to get them. -She got busy serving and providing feeding assistance to a resident and did not know why nutritional supplements were not on the carts for lunch on 05/02/23 and breakfast 05/03/23. Interview with a second PCA on 05/03/23 at 8:50am revealed: -Nutritional supplements were sent on the meal carts from the kitchen. -She knew two residents were to receive nutritional supplements with their meals. -The nutritional supplements were usually on the carts for each meal.	D 310		

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-When supplements were not on the meal cart, a staff that was not providing feeding assistance would go to the kitchen to get them.
-She helped late in the meal to finish with feeding assistance for a resident and was not sure if that resident had a nutritional supplement for breakfast on 05/03/23 or if any staff had went to get the nutritional supplements.

Interview with a MCC on 05/03/23 at 8:58am revealed:
-Nutritional supplements were sent on the meal carts from the kitchen.
-Two residents were to receive nutritional supplements with their meals.
-The nutritional supplements were usually on the meal carts for each meal.
-She did not observe in the dining room every meal, and was unsure of how many times the residents were not served nutritional supplements during meal times.
-If nutritional supplements were not on the meal cart, a staff should have checked with the kitchen to provide nutritional supplements for the residents.

Interview with a dietary aide on 05/03/23 at 9:40am revealed:
-The dietary staff were responsible for sending nutritional supplements on the meal carts for SCU residents who were ordered nutritional supplements with meals.
-She knew two residents were to have nutritional supplements sent on the breakfast, lunch and dinner meal carts.
-The dietary staff had been rushed and did not place them on the meal cart for SCU residents on 05/02/23 for lunch and on 05/03/23 for breakfast.
-No medication aide (MA) or personal care aide (PCA) from the SCU came to the kitchen to ask

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for the residents' nutritional supplements for lunch on 05/02/23 or breakfast on 05/03/23.

Interview with the DM on 05/03/23 at 9:50am revealed:
-The dietary staff were responsible for sending nutritional supplements on the meal carts for SCU residents ordered nutritional supplements with meals.
-He knew two residents were to receive nutritional supplements sent on the breakfast, lunch and dinner meal carts.
-The dietary staff had been rushed to get meal carts out to the SCU and did not place the nutritional supplements on the meal cart on 05/02/23 for lunch and on 05/03/23 for breakfast.
-No MA or PCA from the SCU came to the kitchen to ask for the residents' nutritional supplements for lunch on 05/02/23 or breakfast on 05/03/23.

Interview with the Administrator on 05/03/23 at 2:15pm revealed:
-She was not aware nutritional supplements were not served for lunch on 05/02/23 and breakfast on 05/03/23 in the SCU.
-If the nutritional supplements were not sent on the meal carts, she expected staff to go to the kitchen door and ask for the nutritional supplements for the residents.
-She expected all nutritional supplements to be provided by dietary and given to residents with meals as ordered.

3. Review of Resident #4's current FL2 dated 10/22/22 revealed diagnoses included diabetes mellitus and anemia.

Review of Resident #4's wound care clinic discharge instructions dated 03/08/23, 04/10/23

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and 04/24/23 revealed:
-She was seen for visits for an open wound of the abdomen.
-There were orders to start drinking a protein supplement daily for wound healing.

Observation of the kitchen freezer on 05/03/23 at 9:30am revealed there were no protein supplements available to provide to Resident #4.

Interview with a dietary aide on 05/03/23 at 9:40am revealed:
-The dietary staff were responsible to provide nutritional supplements and protein supplements for residents who were ordered supplements.
-She was not aware Resident #4 had an order for a daily protein supplement.

Interview with the Dietary Manager (DM) on 05/03/23 at 9:50am revealed:
-The dietary staff were responsible for sending out nutritional supplements and protein supplements for residents as ordered with meals.
-He did not know that Resident #4 had an order for a daily protein supplement.

Interview with Resident #4 on 05/03/23 at 1:45pm revealed:
-She went to the wound care clinic every 3 or 4 weeks for an open area on her abdomen.
-She did not remember staff at the wound care clinic telling her she had to start drinking a protein supplement every day, and she had not received any protein supplements from the facility staff.
-She did not see discharge papers, because the transporter took them to the MAs when she got back from appointments.
-She really needed extra nutrition to help her wound heal.

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D 310	Continued From page 19 Telephone interview with a representative from Resident #4's primary care provider's (PCP) office on 05/03/23 at 2:26pm revealed: -Resident #4 was referred to the wound care clinic for an abdominal wound. -The PCP would expect any instructions from the wound care clinic to have been followed up on. - Resident #4 needed a protein supplement for wound healing. -The facility should have contacted the ordering provider at the wound care clinic to obtain a written order if the facility needed one. -There was no documentation that facility staff requested a written order for a daily protein supplement. Telephone interview with a representative from Resident #4's wound care clinic on 05/03/23 at 4:46 revealed: -Resident #4 had been seen for an open wound to her abdomen. -The discharge instructions for Resident #4 on 03/08/23 and afterward were considered orders for a daily protein supplement for wound healing. -If the facility needed orders written differently, they should have contacted the office and prescriptions would have been written or sent electronically to the resident's pharmacy. -It was expected that the facility would obtain the protein supplement, even if they were over the counter, and administer the protein supplements to Resident #4. -She could not speak to negative effects if Resident #4 did not receive the protein supplement daily. Interview with the Resident Care Coordinator (RCC) on 05/03/23 at 10:40am revealed: -He reviewed the residents' orders when they returned from appointments.	D 310		

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D 310	Continued From page 20 -The facility sent an order sheet with Resident #4 that the wound care provider had written wound care orders on, but not the daily protein supplement. -He would not have looked through the pages of her discharge summary, because he had the facility's signed order sheet with other orders on it. -He missed the instructions for Resident #4 from the wound care clinic to start drinking a protein supplement daily. -If he had seen the instructions, he would have called the PCP and requested orders to be sent to the pharmacy. Interview with the Administrator on 05/03/23 at 2:15pm revealed: -She was not aware Resident #4 had instructions on a discharge summary to start drinking a protein supplement every day. -The RCC reviewed the facility's order sheet that was sent with resident's going to appointments. -She did not expect the RCC to review instructions on a discharge summary, because the providers filled out the facility's order sheet. -The wound care clinic provider did not list a daily protein supplement on the facility's order sheet, so that order was missed. -She expected all physician's orders to be followed as ordered.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358		

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(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, record reviews and interviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1 and #4) who had orders for a narcotic pain medication and an antipsychotic medication (#1), and orders for vitamin and mineral supplements for wound healing (#4).

The findings are:

1. Review of Resident #1's current FL2 dated 08/24/22 revealed diagnoses included Alzheimer's disease, dementia, insomnia, hypertension and osteoporosis.

a. Review of Resident #1's physician's order dated 10/04/22 revealed an order for hydrocodone-acetaminophen 5-325mg (a Schedule II narcotic used to treat moderate pain) take 1 tablet every 6 hours.

Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for hydrocodone-acetaminophen 5-325mg, take 1 tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation hydrocodone-acetaminophen was not administered at 12:00am on 02/13/23, 02/14/23,

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02/16/23, and 02/18/23 due to waiting for the medication to arrive from the pharmacy or physically unable to take.
-There was documentation hydrocodone-acetaminophen was not administered at 6:00am on 02/13/23, 02/15/23, and 02/17/23 due to waiting for the medication to arrive from the pharmacy or physically unable to take.
-There was documentation hydrocodone-acetaminophen was not administered at 12:00pm on 02/13/23, 02/15/23, and 02/18/23 due to medication not available for administration and new prescription was sent to the pharmacy from hospice.
-There was documentation hydrocodone-acetaminophen was not administered at 6:00pm on 02/13/23, 02/14/23, 02/15/23, 02/16/23, 02/17/23, and 02/18/23 due to waiting for the medication to arrive from the pharmacy, physically unable to take, or prescription needed a refill.

Review of Resident #1's controlled substance count sheet (CSCS) dated 01/27/23 revealed:
-Hydrocodone-acetaminophen 5-325mg take 1 tablet every 6 hours was dispensed for a quantity of 60 tablets which was a 15-day supply.
-There was documentation that the last tablet signed out was at 6:00pm on 02/12/23.

Review of Resident #1's CSCS dated 02/18/23 revealed:
-Hydrocodone-acetaminophen 5-325mg take 1 tablet every 6 hours was dispensed for a quantity of 60 tablets which was a 15-day supply.
-There was documentation that the first tablet signed out was at 6:00pm on 02/18/23.
-There was no documentation hydrocodone-acetaminophen 5-325mg was

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signed out between 12:00am on 02/13/23 and 12:00pm on 02/18/23.

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for hydrocodone-acetaminophen 5-325mg, take 1 tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation hydrocodone-acetaminophen was not administered on 03/06/23 at 6:00am or 6:00pm due to waiting for the medication to arrive from the pharmacy and physically unable to take.
-There was documentation hydrocodone-acetaminophen was not administered on 03/07/23 at 6:00pm due to physically unable to take.
-There was documentation hydrocodone-acetaminophen was not administered on 03/08/23 at 12:00am, 6:00am, 12:00pm or 6:00pm due to waiting on a refill from the pharmacy.

Review of Resident #1's CSCS dated 02/18/23 revealed:
-Hydrocodone-acetaminophen 5-325mg take 1 tablet every 6 hours was dispensed for a quantity of 60 tablets which was a 15-day supply.
-There was documentation that the last tablet signed out was at 6:00pm on 03/05/23.

Review of Resident #1's CSCS dated 03/08/23 revealed:
-Hydrocodone-acetaminophen 5-325mg take 1 tablet every 6 hours was dispensed for a quantity of 60 tablets which was a 15-day supply.
-There was documentation that the first tablet signed out was at 12:00am on 03/09/23.
-There was no documentation that

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hydrocodone-acetaminophen was signed out between 12:00am on 03/06/23 and 6:00pm on 03/08/23.

Review of Resident #1's physician's order dated 04/06/23 revealed:
-There was an order to discontinue hydrocodone-acetaminophen 5-325mg 1 tablet every 6 hours.
-There was an order to start hydrocodone-acetaminophen 10-325mg take 1 tablet every 6 hours.

Review of Resident #1's April 2023 eMAR revealed:
-There was an entry for hydrocodone-acetaminophen 5-325mg, take 1 tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm with a discontinued date of 04/06/23.
-There was an entry for hydrocodone-acetaminophen 10-325mg, take 1 tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 04/06/23.
-There was documentation hydrocodone-acetaminophen was not administered from 6:00pm on 04/22/23 through 6:00pm on 04/23/23 due to waiting on a refill from the pharmacy and physically unable to take.

Review of Resident #1's CSCS dated 03/28/23 revealed:
-Hydrocodone-acetaminophen 10-325mg take 1 tablet every 6 hours was dispensed for a quantity of 60 tablets which was a 15-day supply.
-There was documentation that the last tablet signed out was at 12:00pm on 04/22/23.

Review of Resident #1's CSCS dated 04/23/23

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revealed:
-Hydrocodone-acetaminophen 10-325mg take 1 tablet every 6 hours was dispensed for a quantity of 90 tablets which was a 22-day supply.
-There was documentation that the first tablet signed out was at 12:00am on 04/23/23.
-There was no documentation that hydrocodone-acetaminophen was signed out from the 6:00pm dose on 04/22/23 through the 6:00pm dose on 04/23/23.

Review of Resident #1's Progress Notes revealed:
-On 02/13/23 at 10:54am, after missing two scheduled doses of hydrocodone-acetaminophen, there was documentation that Resident #1 had been more combative and aggressive that morning.
-On 02/15/23 at 12:44am, there was documentation that Resident #1 did not get her 12:00am dose of hydrocodone-acetaminophen and they were still waiting on the delivery of the medication from the pharmacy.
-On 03/06/23 at 9:47am, after missing two scheduled doses of hydrocodone-acetaminophen, there was documentation that Resident #1 had been more combative towards staff and other residents and she was yelling and screaming.

Review of Resident #1's hospice interdisciplinary group comprehensive assessment and plan of care update report dated 02/24/23 revealed:
-The hospice nurse documented that on 02/18/23 Resident #1 was agitated.
-The hospice nurse found a medication error related to Resident #1 having been out of her scheduled prescription for hydrocodone-acetaminophen since 02/12/23.
-The hospice nurse notified the hospice doctor

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and had a refill for the hydrocodone-acetaminophen prescription sent to the pharmacy.
-The hospice nurse provided education to the facility staff about the medication error, withdrawal symptoms, and medication compliance.
-The hospice nurse instructed facility staff to request medication refills prior to the medication running out and the facility staff voiced understanding.
-Resident #1's pulse on 02/18/23 when she had missed 23 doses of hydrocodone-acetaminophen was 90 beats per minute (bpm)(her pulse range from 01/27/23 through 02/23/23, on the days she received hydrocodone-acetaminophen, was 59 bpm to 80 bpm) and her blood pressure was 146/72 (her blood pressure range from 01/27/23 through 02/23/23, on the days she received hydrocodone-acetaminophen, was 100/60 to 124/68).

Observation of medications on hand for Resident #1 on 05/02/23 at 2:55pm revealed:
-There were two medication cards containing hydrocodone-acetaminophen 10-325mg with a dispensed date of 04/23/23.
-There were 56 out of 90 dispensed tablets remaining in the medication cards.

Observation of Resident #1 on 05/02/23 at 11:40am revealed she was sitting on the couch in the common area, awake, and calm.

Observations of Resident #1 on 05/02/23 at 2:49pm and on 05/03/23 at 11:24am revealed she was laying quietly in bed in her room.

Telephone interview with a representative from the facility's contracted pharmacy on 05/02/23 at

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D 358	Continued From page 27 3:25pm revealed: -Hydrocodone-acetaminophen 5-325mg tablets were dispensed for Resident #1 on 01/27/23 for a quantity of 60 tablets. -Hydrocodone-acetaminophen 5-325mg tablets were dispensed for Resident #1 on 02/18/23 for a quantity of 60 tablets. -Hydrocodone-acetaminophen 5-325mg tablets were dispensed for Resident #1 on 03/08/23 for a quantity of 60 tablets. -Hydrocodone-acetaminophen 5-325mg tablets were dispensed for Resident #1 on 03/20/23 for a quantity of 60 tablets. -Hydrocodone-acetaminophen 10-325mg tablets were dispensed for Resident #1 on 03/28/23 for a quantity of 60 tablets. -Hydrocodone-acetaminophen 10-325mg tablets were dispensed for Resident #1 on 04/23/23 for a quantity of 90 tablets. Telephone interview with a representative from Resident #1's hospice physician's office on 05/03/23 at 10:10am revealed: -Hospice was aware that the facility staff did not contact them to request refills of hydrocodone prior to the medication running out. -On 02/13/23, during the chaplain's visit with Resident #1, it was documented that Resident #1 was agitated and pulling at her hair. -On 02/18/23, during the hospice nurse's visit, she arrived at Resident #1's room to find her laying in bed yelling out and staff had reported to her that Resident #1 had "been like that" for several days. -The hospice nurse checked inventory on the medication cart and discovered Resident #1 did not have hydrocodone-acetaminophen available, then realized she had gone without taking hydrocodone since 02/12/23. -The hospice nurse provided education to the	D 358		

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facility staff about requesting refills at least a couple of days prior to the medication running out so they had time to reorder the prescription.

Interview with Resident #1's hospice nurse on 05/03/23 at 10:40am revealed:
-She had known Resident #1 since she was first admitted to hospice in February 2022.
-Resident #1 was not able to communicate her needs due to her dementia.
-When Resident #1 ran out of hydrocodone-acetaminophen, she had been agitated and yelling out while laying in bed.
-On 02/20/23, when Resident #1 was back on her scheduled routine of taking hydrocodone-acetaminophen, staff had reported that she was more calm since taking the pain medication again.
-Hospice expected the facility staff to contact them when Resident #1 was down to the last several days' worth of doses.
-Hospice was able to have a prescription refill at the pharmacy within a day.

Interview with the Memory Care Coordinator (MCC) on 05/03/23 at 1:45pm revealed:
-She and the medication aides (MAs) tried to notify the hospice staff of needed refills during their visits to the facility, but then the facility had to wait for the prescription to be sent to the pharmacy and delivered to them at the facility.
-Usually, the hospice nurse checked the medication cart to see how much hydrocodone was remaining and staff did not have to request refills.
-The MAs were expected to click the "refill" button in the eMAR when Resident #1 was down to 8 doses remaining.
-She was not aware that Resident #1 had ran out of hydrocodone-acetaminophen between refills in

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D 358	Continued From page 29 February, March and April 2023. -Some behaviors that Resident #1 had included refusing to get out of bed in the morning, holding on her to bed rail and shaking it, yelling at staff, and being combative with staff. -She did not remember if Resident #1 had behaviors during the days she had not taken hydrocodone. Interview with a MA on 05/03/23 at 2:25pm revealed: -She worked the day before Resident #1 ran out of hydrocodone-acetaminophen in February 2023, and worked on 02/14/23 after Resident #1 had ran out of hydrocodone-acetaminophen. -She worked on 04/23/23 when Resident #1 had been out of hydrocodone-acetaminophen. -The hospice nurse came to the facility to see Resident #1 at least once or twice a week and the MAs let the hospice nurse know that a refill was needed if the medication was down to the blue-shaded row (last 8 doses) of the medication card. -She thought she had attempted to refill Resident #1's hydrocodone-acetaminophen in February 2023, but the pharmacy did not send the prescription because the pharmacy needed the doctor's written order. -She let someone know about Resident #1's hydrocodone prescription needing to be reordered, but she could not remember who. -Resident #1 did not have any increased agitation or behaviors when she was out of hydrocodone. Interview with a second MA on 05/03/23 at 3:15pm revealed: -She worked in February 2023 when Resident #1 had been out of hydrocodone-acetaminophen. -She worked the day before Resident #1 ran out of hydrocodone-acetaminophen in April 2023.	D 358		

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-When Resident #1's hydrocodone-acetaminophen was down to the last 8 tablets, the MAs were supposed to click the "refill" button in the eMAR, the pharmacy would send staff a notice that a written prescription was needed from the doctor.
-The MA would have to call hospice to request a refill, and they would send the prescription to the pharmacy.
-Once hospice staff sent the prescription to the pharmacy, it would be delivered that same evening.
-Hospice could order hydrocodone-acetaminophen to be delivered right away and the facility would have the prescription within hours.
-She could not remember if she had requested a refill for Resident #1's hydrocodone-acetaminophen in April 2023.
-She did not remember Resident #1 having increased agitation or yelling out on the days when she did not take hydrocodone-acetaminophen.
-The MAs and the MCC did medication cart audits every Monday, Wednesday, and Friday, but they had a rotation of which residents' medications they audited.
-During the medication cart audits, they checked the quantity of medications remaining.
-She did not know why Resident #1 had ran out of hydrocodone-acetaminophen between refills in February, March and April 2023 when the MAs, the MCC and the hospice nurse all did medication cart audits.

Interview with a third MA on 05/03/23 at 3:40pm revealed:
-She had documented Resident #1's hydrocodone-acetaminophen as not administered three times in February 2023, four times in March

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2023, and two times in April 2023.
-Since the hospice nurse came and counted Resident #1's hydrocodone-acetaminophen once or twice a week, she did not request refills of the hydrocodone-acetaminophen any of the times she ran out because she thought the hospice nurse already knew it needed to be refilled.
-If Resident #1's hydrocodone-acetaminophen was running low the MAs would let the hospice nurse know during her in-person visits.
-She could not remember if Resident #1 had increased agitation, behaviors or yelling out on the days she did not take hydrocodone-acetaminophen.

Interview with the Administrator on 05/03/23 at 4:00pm revealed:
-The MAs were expected to request medication refills once the quantity remaining reached the blue-shaded, last column of the medication card.
-The MAs were supposed to click the "refill" button on the eMAR, and when the pharmacy sent their note saying that a written prescription was needed, staff were supposed to call hospice with that information.
-If the MAs first requested a refill of Resident #1's hydrocodone-acetaminophen when the quantity remaining first reached the blue-shaded column of the medication card, there would be enough time to get the prescription in the facility prior to it running out.
-The pharmacy delivered medications in the morning and in the evening so if a medication refill was requested it either came that same evening or the following morning.
-The MCC was supposed to be completing audits on the eMARs at the same time she was auditing the medication carts and each resident was audited at least once per month.
-She did not know why Resident #1 had ran out of

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hydrocodone-acetaminophen between refills for the last three months.
-She expected refills to be requested prior to the medications running out.
-She expected medications to be administered as ordered.

Based on observation of medications on hand, review of Resident #1's February, March and April 2023 eMARs, and telephone interview with the facility's contracted pharmacy, Resident #1 was not administered a total of 41 doses of hydrocodone-acetaminophen from 02/01/23 through 04/30/23.

Attempted telephone interview with Resident #1's power of attorney (POA) on 05/03/23 at 11:32am was unsuccessful.

Based on observation, record review and interview, it was determined Resident #1 was not interviewable.

b. Review of Resident #1's current FL2 dated 08/24/22 revealed an order for quetiapine (an antipsychotic medication used to treat schizophrenia, bipolar disorder and depression) 100mg twice daily.

Review of Resident #1's hospice physician's order dated 09/08/22 revealed an order to change quetiapine order to take 50mg in the morning and afternoon and 100mg at bedtime.

Review of Resident #1's hospice physician's order dated 01/27/23 revealed:
-There was an order to discontinue quetiapine 50mg in the morning and afternoon and 100mg at bedtime.
-There was an order to start quetiapine 100mg

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three times daily.

Review of Resident #1's February 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine 50mg twice daily scheduled at 9:00am and 5:00pm.
-There was documentation quetiapine 50mg was administered twice daily from 02/01/23 through 02/28/23.
-There was an entry for quetiapine 100mg at bedtime scheduled at 9:00pm.
-There was documentation quetiapine 100mg was administered at 9:00pm from 02/01/23 through 02/28/23.

Review of Resident #1's March 2023 eMAR revealed:
-There was an entry for quetiapine 50mg twice daily scheduled at 9:00am and 5:00pm.
-There was documentation quetiapine 50mg was administered twice daily from 03/01/23 through 03/31/23.
-There was an entry for quetiapine 100mg at bedtime scheduled at 9:00pm.
-There was documentation quetiapine 100mg was administered at 9:00pm from 03/01/23 through 03/31/23.

Review of Resident #1's April 2023 eMAR revealed:
-There was an entry for quetiapine 50mg twice daily scheduled at 9:00am and 5:00pm.
-There was documentation quetiapine 50mg was administered twice daily from 04/01/23 through 04/30/23.
-There was an entry for quetiapine 100mg at bedtime scheduled at 9:00pm.
-There was documentation quetiapine 100mg was administered at 9:00pm from 04/01/23

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through 04/30/23.

Review of Resident #1's May 2023 eMAR from 05/01/23/ through 05/02/23 revealed:
-There was an entry for quetiapine 50mg twice daily scheduled at 9:00am and 5:00pm.
-There was documentation quetiapine 50mg was administered at 9:00am and 5:00pm on 05/01/23, and at 9:00am on 05/02/23.
-There was an entry for quetiapine 100mg at bedtime scheduled at 9:00pm.
-There was documentation quetiapine 100mg was administered at 9:00pm on 05/01/23.

Review of Resident #1's hospice interdisciplinary group comprehensive assessment and plan of care update report dated 02/10/23 revealed:
-There was documentation that the hospice doctor increased Resident #1's quetiapine dose to 100mg three time daily on 01/27/23.
-There was documentation from the hospice pastor/counselor that facility staff reported that Resident #1 had been agitated during the weekend and throughout the last week.

Review of Resident #1's hospice interdisciplinary group comprehensive assessment and plan of care update report dated 03/24/23 revealed:
- There was documentation from the hospice pastor/counselor that facility staff reported to her that Resident #1 had been yelling, cursing loudly and running over other residents' feet with her wheelchair.

Observation of medication on hand for Resident #1 on 05/02/23 at 2:55pm revealed:
-There were two medication cards for quetiapine 50mg twice daily with a dispensed date of 03/30/23; one medication card had 5 out of 30 dispensed tablets remaining and the second

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medication card had 30 out of 30 dispensed tablets remaining.
-There was one medication card for quetiapine 100mg at bedtime with a dispensed date of 04/07/23 and had 12 out of 30 dispensed tablets remaining.

Observation of Resident #1 on 05/02/23 at 11:40am revealed she was sitting on the couch in the common area, awake, and calm.

Observations of Resident #1 on 05/02/23 at 2:49pm and on 05/03/23 at 11:24am revealed she was laying quietly in bed in her room.

Telephone interview with a representative from the facility's contracted pharmacy on 05/02/23 at 3:25pm revealed:
-The current order they had was for quetiapine was 50mg twice daily and 100mg at bedtime.
-The pharmacy did not receive the order dated 01/27/23 to increase Resident #1's quetiapine dose to 100mg three times daily.

Telephone interview with representative for Resident #1's hospice physician's office on 05/03/23 at 10:10am revealed:
-On 01/27/23. the hospice doctor discontinued Resident #1's quetiapine order for 50mg twice daily and 100mg at bedtime and replaced it with an order for quetiapine 100mg three times daily.
-The current order they had on Resident #1's medication list with hospice was quetiapine 100mg three times daily.
-They expected the facility to be administering quetiapine 100mg three times daily to Resident #1 as ordered by the hospice doctor.
-Resident #1 was prescribed quetiapine to help manage agitation and behaviors.
-Resident #1 had been having episodes of

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agitation and pulling her hair out, and that was the reason the hospice doctor increased the quetiapine dose to 100mg three times daily.
-Resident #1 had continued behaviors after the quetiapine dose was increased on 01/27/23, so the hospice doctor wrote an order to increase the dose of her narcotic pain medication, thinking that the behaviors could be pain-related.
-They were not aware that Resident #1's quetiapine dose was never increased and she was still receiving 50mg in the morning and afternoon instead of 100mg.
-There was documentation from the hospice chaplain on 02/13/23 that Resident #1 was agitated and pulling at her hair.
-There was documentation from the hospice nurse on 03/20/23 that the medication aide (MA) at the facility reported to the hospice nurse that Resident #1 had been aggressive, agitated, and intentionally rolling over other resident's feet with her wheelchair.
-There was documentation from the hospice nurse on 04/21/23 that Resident #1 was exhibiting symptoms of anxiety and agitation during her visit.
-Resident #1's ongoing episodes of agitation and yelling out could be contributed to her quetiapine dose not being increased as ordered.

Interview with Resident #1's hospice nurse on 05/03/23 at 10:40am revealed:
-Resident #1 was prescribed quetiapine to help manage her behaviors.
-Resident #1's quetiapine order was for 100mg three times daily.
-She was not aware that Resident #1 was still receiving quetiapine 50mg in the morning and afternoon rather than 100mg as ordered.
-Resident #1's behaviors included being combative with staff, yelling, and pulling her hair

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D 358	Continued From page 37 out. Interview with the Memory Care Coordinator (MCC) on 05/03/23 at 1:45pm revealed: -When the hospice doctor wrote new medication orders, the order was faxed to the facility. -Once the faxed order arrived at the facility, either herself or a MA would take the order and fax it to the pharmacy, and write their initials on the order to indicate that it had been processed. -There were no initials on the order to increase Resident #1's dose of quetiapine to 100mg three times daily, so she did not know who put the order into the resident record without faxing it to the pharmacy. -She had never seen the order to increase Resident #1's quetiapine dose dated 01/27/23. -She only audited new medication orders as they came; she did not go back through the resident records to review previous orders and ensure no orders had been missed. -Resident #1 had not pulled at her hair in a couple of months, but she had other behaviors such as yelling out and being combative with staff at times. Interview with a MA on 05/03/23 at 2:25pm revealed: -When the hospice doctor wrote a new medication order, they usually sent the prescription right to the pharmacy or faxed the order to the facility. -Either a MA or the MCC could fax new medication orders to the pharmacy, but usually the MCC took that responsibility. -She had not seen the order to increase Resident #1's quetiapine dose to 100mg three times daily. -Medication cart audits were completed every week, but they compared the medication in the cart to the medication order.	D 358		

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D 358	Continued From page 38 -The order in their eMAR system was still for quetiapine 50mg in the morning and afternoon and 100mg at bedtime; so there was no discrepancy. -The pharmacy entered medication orders into the eMAR, so if the pharmacy did not receive the new quetiapine order on 01/27/23, the eMAR did not get updated. -Resident #1 had behaviors, usually once a week, including yelling out or being combative with staff. Interview with a second MA on 05/03/23 at 3:15pm revealed: -If hospice wrote a new prescription order, the MCC was responsible for processing that order by faxing it to the pharmacy and approving the new order in the eMAR. -If the MCC was not working when a new prescription order was faxed to the facility from hospice, then whoever the supervisor was would be responsible for processing the order. -She had never seen the order to increase Resident #1's quetiapine dose to 100mg three times daily. -Since there were no initials written on the order it was possible someone took the order off the fax machine and put it into Resident #1's record without faxing it to the pharmacy. -Resident #1 sometimes had behaviors of yelling at staff or refusing personal care. -Resident #1 had not pulled at her hair in the previous couple of months. Interview with a third MA on 05/03/23 at 3:40pm revealed: -Any MA could take a new prescription order from the fax machine and put it into the resident's record, but they were supposed to check and see that the order was current in the eMAR prior to doing so.	D 358		

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	HAL034116	A. BUILDING: _____ B. WING _____	R 05/03/2023

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-She had not seen Resident #1's order to increase quetiapine to 100mg three times daily.
-Resident #1 usually had behaviors for day shift rather than second shift when she worked.
-When Resident #1 did have behaviors on second shift it was usually just yelling out.
-The last time Resident #1 had a behavior when she was working was a couple weeks ago.

Interview with the Administrator on 05/03/23 at 4:00pm revealed:
-The MCC was responsible for ensuring all new medication orders were faxed to the pharmacy.
-If a MA helped the MCC by faxing an order, it was still the MCC's responsibility to follow-up on the order change and ensure it had been correctly entered into the eMAR.
-She was not aware that Resident #1's order to increase quetiapine to 100mg three times daily had not been faxed to the pharmacy or changed on the eMAR.
-She was not aware of Resident #1 having any excessive behaviors because staff had not reported concerns to her.
-She was aware that Resident #1 sometimes yelled out and liked to be repositioned often.
-She expected all medications to be administered as ordered.

Attempted telephone interview with Resident #1's power of attorney (POA) on 05/03/23 at 11:32am was unsuccessful.

Based on observation, record review and interview, it was determined Resident #1 was not interviewable.

2. Review of Resident #4's current FL2 dated 10/22/22 revealed diagnoses included diabetes mellitus and anemia.

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D 358	Continued From page 40 a. Review of Resident #4's wound care clinic discharge instructions dated 03/08/23, 04/10/23 and 04/24/23 revealed: -She was seen for visits for an open wound of the abdomen. -There were orders to start taking vitamin A (a vitamin supplement) daily for wound healing and to have a pharmacist advise dosage recommendations. Review of Resident #4's March, and April 2023 electronic medication administration record (eMAR) revealed: -There was no entry for vitamin A daily. -There was no documentation that vitamin A was administered daily from 03/08/23 through 03/31/23 and from 04/01/23 through 04/30/23. Review of Resident #4's May 2023 eMAR from 05/01/23 through 05/02/23 revealed: -There was no entry for vitamin A daily. -There was no documentation that vitamin A was administered daily from 05/01/23 through 05/02/23. Observation of Resident #4's medications on hand on 05/03/23 at 2:00pm revealed there were no vitamin A available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/02/23 at 3:18pm revealed: -Resident #4 did not have a physician's order for vitamin A. -The pharmacy received orders electronically or via fax on the facility's order sheets. -When the pharmacy received orders, they added the orders to the eMAR and dispensed the medications.	D 358		

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D 358	Continued From page 41 Observation of Resident #4's abdominal wound on 05/03/23 at 1:20pm revealed: -There were two small open areas (wounds) on the right lower abdomen; one wound was 1 centimeter in size and the second wound was 2.5 centimeters in size, with an intact dressing dated and initialed on 05/03/23. -There was no redness, drainage or odor noted. Interview with Resident #4 on 05/03/23 at 1:45pm revealed: -She went to the wound care clinic every 3 or 4 weeks for an open area on her abdomen. -She did not remember staff at the wound care clinic telling her she had to start taking vitamins A. -She did not see discharge papers because the transporter took them to the MAs when she got back from appointments. -She really needed extra nutrition to help her wounds to heal. b. Review of Resident #4's wound care clinic discharge instructions dated 03/08/23, 04/10/23 and 04/24/23 revealed: -She was seen for visits for an open wound of the abdomen. -There were orders to start taking vitamin C (a vitamin supplement) daily for wound healing and to have a pharmacist advise dosage recommendations. Review of Resident #4's March and April 2023 electronic medication administration record (eMAR) revealed: -There was no entry for vitamin C daily. -There was no documentation that vitamin C was administered daily from 03/08/23 through 03/31/23 and from 04/01/23 through 04/30/23.	D 358		

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Review of Resident #4's May 2023 eMAR from 05/01/23 through 05/02/23 revealed:
-There was no entry for vitamin C daily.
-There was no documentation that vitamin C was administered daily from 05/01/23 through 05/02/23.

Observation of Resident #4's medications on hand on 05/03/23 at 2:00pm revealed there were no vitamin C available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 05/02/23 at 3:18pm revealed:
-Resident #4 did not have a physician's order for vitamin C.
-The pharmacy received orders electronically or via fax on the facility's order sheets.
-When the pharmacy received orders, they added the orders to the eMAR and dispensed the medications.

Interview with Resident #4 on 05/03/23 at 1:45pm revealed:
-She went to the wound care clinic every 3 or 4 weeks for an open area on her abdomen.
-She did not remember staff at the wound care clinic telling her she had to start taking vitamins C.
-She did not see discharge papers because the transporter took them to the MAs when she got back from appointments.
-She really needed extra nutrition to help her wounds to heal.

c. Review of Resident #4's wound care clinic discharge instructions dated 03/08/23, 04/10/23 and 04/24/23 revealed:
-She was seen for visits for an open wound of the abdomen.

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D 358	Continued From page 43 -There were orders to start taking zinc (a mineral supplement) daily for wound healing and to have a pharmacist advise dosage recommendations. Review of Resident #4's March and April 2023 electronic medication administration record (eMAR) revealed: -There was no entry for zinc daily. -There was no documentation that zinc was administered daily from 03/08/23 through 03/31/23 and 04/01/23 through 04/30/23. Review of Resident #4's May 2023 eMAR from 05/01/23 through 05/02/23 revealed: -There was no entry for zinc daily. -There was no documentation that zinc was administered daily from 05/01/23 through 05/02/23. Observation of Resident #4's medications on hand on 05/03/23 at 2:00pm revealed there were no zinc available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 05/02/23 at 3:18pm revealed: -Resident #4 did not have a physician's order for zinc. -The pharmacy received orders electronically or via fax on the facility's order sheets. -Whenthe pharmacy received orders, they added the orders to the eMAR and dispensed the medications. Interview with Resident #4 on 05/03/23 at 1:45pm revealed: -She went to the wound care clinic every 3 or 4 weeks for an open area on her abdomen. -She did not remember staff at the wound care clinic telling her she had to start taking zinc.	D 358		

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D 358	Continued From page 44 -She did not see discharge papers because the transporter took them to the MAs when she got back from appointments. -She really needed extra nutrition to help her wounds to heal. Interview with a MA on 05/03/22 at 2:00pm revealed: -She did not remember Resident #4 ever having orders for vitamins A and C or zinc from the wound care clinic. -The facility sent a physician's order sheet for each appointment to write order changes or new orders. -The MAs would not have looked through the pages of discharge instructions because they had the facility's order sheet. -If the Resident Care Coordinator (RCC) was not in the facility, the medication aide (MA) on duty faxed the order sheet to the pharmacy and then placed all paperwork in the RCC's office. -The pharmacy added the new orders to the eMAR and sent the medication that night or the next morning. -The RCC received all discharge papers when residents returned from appointments or the hospital and checked to see that orders were started. Telephone interview with a representative from Resident #4's primary care provider's (PCP) office on 05/03/23 at 2:26pm revealed: -Resident #4 was referred to the wound care clinic for an abdominal wound. -The PCP would expect any instructions from the wound care clinic to have been followed up on. -Resident #4 needed vitamins A and C, and zinc for wound healing. -The facility should have contacted the ordering provider at the wound care clinic to obtain doses	D 358		

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and electronic, written or verbal orders.
-There was no documentation facility staff requested prescriptions for vitamins A and C, and zinc daily.

Telephone interview with a representative from Resident #4's wound care clinic on 05/03/23 at 4:46 revealed:
-Resident #4 had been seen for a healing open wound to her abdomen.
-The discharged instructions for Resident #4 on 03/08/23 and afterward were considered orders for vitamin A and C, and zinc daily for wound healing.
-If the facility needed orders written differently, they should have contacted the office and prescriptions would have been written or sent electronically to the resident's pharmacy.
-It was expected that the facility would obtain the medications, even if they were over the counter, and administer them to Resident #4.
-She could not speak to negative effects if Resident #4 did not receive the vitamins A and C, and zinc daily as ordered.

Interview with the RCC on 05/03/23 at 10:40am revealed:
-He reviewed the residents' orders when they returned from appointments.
-The facility sent an order sheet with Resident #4 that the wound care provider had written wound care orders on, but not the vitamins A and C, and zinc.
-He would not have looked through the pages of her discharge summary, because he had the facility's signed order sheet with other orders on it.
-He missed the instructions for Resident #4 from the wound care clinic to start vitamins A and C, and zinc daily.

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D 358	Continued From page 46 -If he had seen the instructions, he would have called the PCP and requested orders to be sent to the pharmacy. Interview with the Administrator on 05/03/23 at 2:15pm revealed: -She was not aware that Resident #4 had instructions on a discharge summary to start taking vitamins A and C, and zinc daily. -The RCC reviewed the facility's order sheet that was sent with resident's going to appointments. -She did not expect the RCC to review instructions on a discharge summary, because the providers filled out the facility's order sheet. -The wound care clinic provider did not list vitamins A and C, and zinc with dosages on the facility's order sheet and so those orders were missed. -She expected all physician's orders to be followed and all medications administered as ordered. _____ The facility failed to ensure medications were administered as ordered for 2 residents including a resident who had an order for a narcotic pain medication due to an end of life terminal illness that did not receive the narcotic pain medication for 24 doses in February, 12 doses in March, and 5 doses in April 2023 resulting in the resident yelling out, having an increase in her blood pressure and heart rate, and exhibiting agitation; and an order to increase the dose of an antipsychotic medication that was prescribed for behaviors which was never increased resulting in subsequent ongoing behaviors of pulling her hair, yelling, and being combative (Resident #1); and a resident who was not administered her vitamin and mineral supplements needed for wound healing (Resident #4). This failure placed residents at substantial risk for serious physical	D 358		

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D 358	Continued From page 47 harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, JUNE 2, 2023.	D 358		